

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9587

CERTIFICATE OF DEATH

Reg. Dist. No.

09591

202

1. PLACE OF DEATH a. COUNTY <u>Bent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Bent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Robert & Queen Anne</u>		d. STREET ADDRESS <u>RFD</u>	
3. NAME OF DECEASED (Type or print) First <u>FRED</u> (Frederick) Middle <u>HOLDEN</u> Last <u>HOLDEN</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1905</u> 52 yrs.
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Roy Holden</u>		14. MOTHER'S MAIDEN NAME <u>Ida Milburn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-10-6049</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke (intracranial hemorrhage)</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterial hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus (?)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. ft.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/13/57</u> 19 <u>57</u> , to <u>9/15</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9/15</u> 19 <u>57</u> , and that death occurred at <u>10:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Farr</u>		M.D. <u>Chestertown, Md. 9/15/57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT W. FARR</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 19, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sharptown Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walley</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Boney</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John J. Smith</i></p>	
<p>2. Age: <i>45</i></p>	
<p>3. Sex: <i>Male</i></p>	
<p>4. Date of death: <i>Sept 15, 1957</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>Dr. J. H. Jones</i></p>	
<p>8. Signature of registrar: <i>John J. Smith</i></p>	
<p>9. Signature of informant: <i>John J. Smith</i></p>	
<p>10. Signature of witness: <i>John J. Smith</i></p>	
<p>11. Signature of informant: <i>John J. Smith</i></p>	
<p>12. Signature of witness: <i>John J. Smith</i></p>	
<p>13. Signature of informant: <i>John J. Smith</i></p>	
<p>14. Signature of witness: <i>John J. Smith</i></p>	
<p>15. Signature of informant: <i>John J. Smith</i></p>	
<p>16. Signature of witness: <i>John J. Smith</i></p>	
<p>17. Signature of informant: <i>John J. Smith</i></p>	
<p>18. Signature of witness: <i>John J. Smith</i></p>	
<p>19. Signature of informant: <i>John J. Smith</i></p>	
<p>20. Signature of witness: <i>John J. Smith</i></p>	
<p>21. Signature of informant: <i>John J. Smith</i></p>	
<p>22. Signature of witness: <i>John J. Smith</i></p>	
<p>23. Signature of informant: <i>John J. Smith</i></p>	
<p>24. Signature of witness: <i>John J. Smith</i></p>	
<p>25. Signature of informant: <i>John J. Smith</i></p>	
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<p>28. Signature of witness: <i>John J. Smith</i></p>	
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<p>30. Signature of witness: <i>John J. Smith</i></p>	
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<p>71. Signature of informant: <i>John J. Smith</i></p>	
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<p>73. Signature of informant: <i>John J. Smith</i></p>	
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<p>75. Signature of informant: <i>John J. Smith</i></p>	
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<p>77. Signature of informant: <i>John J. Smith</i></p>	
<p>78. Signature of witness: <i>John J. Smith</i></p>	
<p>79. Signature of informant: <i>John J. Smith</i></p>	
<p>80. Signature of witness: <i>John J. Smith</i></p>	
<p>81. Signature of informant: <i>John J. Smith</i></p>	
<p>82. Signature of witness: <i>John J. Smith</i></p>	
<p>83. Signature of informant: <i>John J. Smith</i></p>	
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<p>89. Signature of informant: <i>John J. Smith</i></p>	
<p>90. Signature of witness: <i>John J. Smith</i></p>	
<p>91. Signature of informant: <i>John J. Smith</i></p>	
<p>92. Signature of witness: <i>John J. Smith</i></p>	
<p>93. Signature of informant: <i>John J. Smith</i></p>	
<p>94. Signature of witness: <i>John J. Smith</i></p>	
<p>95. Signature of informant: <i>John J. Smith</i></p>	
<p>96. Signature of witness: <i>John J. Smith</i></p>	
<p>97. Signature of informant: <i>John J. Smith</i></p>	
<p>98. Signature of witness: <i>John J. Smith</i></p>	
<p>99. Signature of informant: <i>John J. Smith</i></p>	
<p>100. Signature of witness: <i>John J. Smith</i></p>	

RECEIVED
SEP 18 1957
BUREAU V. 2

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9588

CERTIFICATE OF DEATH

09592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN life life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 37 (Lifetime)			
f. STREET ADDRESS 414 Cannon St.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Reuben Franklin Jamar				4. DATE OF DEATH Month Day Year Sept. 29, 1957 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1885		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Jamar				14. MOTHER'S MAIDEN NAME Mary Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 214-28-3703		17. INFORMANT Mrs. Reuben Jamar Address 414 Cannon St. Chestertown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 weeks ??	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 481X Influenza						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-26-57 , 19 57 , to 9-27- , 19 57 , that I last saw the deceased alive on 9-29-57 , 19 57 , and that death occurred at 9:09 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 9-30-57							
ACTUAL SIGNATURE A. C. Dick M.D.				DATE SIGNED 9-30-57			
PHYSICIAN'S NAME (Type) A. C. Dick Chestertown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Wells ADDRESS Chestertown, Md.				24a. REC'D BY REGISTRAR OCT 2 1957		24b. REGISTRAR'S SIGNATURE Clara H. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
OCT 2 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09593

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 2 1/2 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Yvette Middle Renee Last Johnson		4. DATE OF DEATH Month September Day 29 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1957
9. AGE (In years last birthday) yrs. 5 Months 4 Days 4		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Albert Johnse n		14. MOTHER'S MAIDEN NAME Elizabeth M. Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital records & mother, Rock Hall, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Unknown. Deceased had been well until 2 days ago. It developed a respiratory infection which seemed mild and had some fever. There was a little diarrhea which the mother called a cold on the bowels. Was cold and dehydrated on admission, with sunken fontanelles. Physician who saw child shortly before death said child appeared normal except that it appeared parasmic. Despite hterapeutic measures, child died 2 1/2 hrs after admission. 795.2	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) after admission.		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr, M. D.		DATE SIGNED Sept. 30, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. I, 1957	
22c. NAME OF CEMETERY OR CREMATORY Sharptown Com.		22d. LOCATION (City, town, or county) (State) nr. Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Waller		24a. REC'D BY REGISTRAR DATE 2 1957	
24b. REGISTRAR'S SIGNATURE Clara Barnes		24c. ADDRESS Chestertown, Md.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
OCT 10 1964
BUREAU

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09594

Reg. Dist. No.

209

9590

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION High St.		d. STREET ADDRESS High St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles M Middle Lloyd Jr. Last Jr.		4. DATE OF DEATH Month Sept. Day 10 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles M. Lloyd Sr.		14. MOTHER'S MAIDEN NAME Lizzie Bradley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Dont know		16. SOCIAL SECURITY NO. no	
17. INFORMANT John Powell		Address Hotel 2400 Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary insufficiency DUE TO (c) several months		INTERVAL BETWEEN ONSET AND DEATH don't know	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decomposition had begun. Was heard moving around house evening of 9/10 Not seen 9/10/57. Died 9/10/57 P.M.		19. WAS AUTOPSY PERFORMED? XX YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Hour o. m. p. m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 , 19 57 , to Sept. 10 , 19 57 , that I last saw the deceased alive on Sept. 10 , 19 57 , and that death occurred at 7 P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED Sept. 12, 1957	
ACTUAL SIGNATURE Robert W. Farr		M.D. Chestertown, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/13 / 1957	22c. NAME OF CEMETERY OR CREMATORY Sudlersville Cem.	22d. LOCATION (City, town, or county) (State) Sudlersville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Willis Wells		ADDRESS Chestertown, Md.	
24. REG'D BY REGISTRAR SEP 13 1957		24b. REGISTRAR'S SIGNATURE Carol Barnes	

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 13 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9591

Item 9 Filed 9-10-57 et

CERTIFICATE OF DEATH

Reg. Dist. No. 09595

203

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ind b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES FRANKLIN WOOD				4. DATE OF DEATH Month SEPT Day 1 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/1898	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN				10b. KIND OF BUSINESS OR INDUSTRY Whiskey		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John C. Wood				14. MOTHER'S MAIDEN NAME FANNY SAPPINGTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. 317-14-8492			
17. INFORMANT GORDON WOOD				Address Rock Hall			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Jan 1 - , 19 55 , to Sept 1 , 19 57 , that I last saw the deceased alive on Sept 1 , 19 57 , and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall DATE SIGNED Sept 3/57							
ACTUAL SIGNATURE NORBERT C NITSCH M.D.				PHYSICIAN'S NAME (Type) NORBERT - C NITSCH - ROCK HALL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 3RD		22c. NAME OF CEMETERY OR CREMATORY WESLEY		22d. LOCATION (City, town, or county) (State) Rock Hall Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L Lane				ADDRESS Church Hill Md.		24a. REC'D BY REGISTRAR SEP 5 1957	
				24b. REGISTRAR'S SIGNATURE Clara Burgess			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

CERTIFICATE OF DEATH

1957

RECEIVED
SEP 5 1957
BUREAU V. I.